



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Trenton D. Weeks, DC

Respondent Name

XL Specialty Insurance Company

MFDR Tracking Number

M4-13-1343-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 28, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 02/07/12 I performed an evaluation to determine maximum medical improvement and impairment of the above named claimant. I performed this examination at the request of the injured employee and the treating doctor.

03/08/12 Carrier EOR indicates code: (197) Precertification/ Authorization notification absent.

Response: This examination was performed for the purpose of determining MMI and Impairment as it related to the work injury of 02/23/2009. My certification and authorization to evaluate and certify MMI and IR remains current, active and has not been revoked or suspended at any time. This examination and report in no way constitutes treatment and was referred by the treating doctor. This report and bill was performed according to TDWC rules and should be paid in full.

07/03/2012 Carrier EOR denial of reconsideration indicates code: (39) Service denied at the time authorization/pre-certification was requested.

Response: This examination was performed for the purpose of determining MMI and Impairment as it related to the work injury of 02/23/2009. This evaluation and report does not in any way constitute treatment of the injured worker and is not subject to preauthorization requirements in accordance with Labor Code §413.014. Authorization to perform this evaluation is not required nor was it requested. DWC-TWCC affords the injured employee assignment of MMI and impairment by certified doctor. As indicated in the MMI/IR report of the above named claimant, a full physical examination including Range of Motion was conducted on the lower extremity (left knee). This examination and report in no way constitutes treatment and was referred by the treating doctor as indicated in the DWC-69. This report and bill was performed according to TDWC rules and should be paid in full."

Amount in Dispute: \$650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on February 5, 2013. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 7, 2012	99456	\$650.00	\$650.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 defines services subject to pre-authorization requirements.
3. 28 Texas Administrative Code §130.1 (a) identifies providers who are authorized to evaluate maximum medical improvement and impairment rating.
4. 28 Texas Administrative Code §134.204 provides the fee guidelines for the requested services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197/A73 – Precertification/Authorization/Notification absent.
 - 39/A72 – Services denied at the time authorization/pre-certification was requested.

Issues

1. Are the requested services subject to pre-authorization requirements defined in 28 Texas Administrative Code §134.600?
2. Was the requestor authorized to evaluate maximum medical improvement and impairment rating at the time services were performed?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied services stating that precertification/authorization/notification was absent or denied at time of request. Review of the submitted documentation finds that the requested services are division-specific services and not subject to the pre-authorization requirements found in 28 Texas Administrative Code §134.600.
2. 28 Texas Administrative Code §130.1 (a), effective March 14, 2004, 29 TexReg 2328, states, "Authorized Doctor (1) Only an authorized doctor may certify maximum medical improvement (MMI), determine whether there is permanent impairment, and assign an impairment rating if there is permanent impairment. (A) Doctors serving in the following roles may be authorized as provided in subsection (a)(1)(B) of this section. (i) the treating doctor (**or a doctor to whom the treating doctor has referred the injured employee for evaluation of MMI and/or permanent whole body impairment** in the place of the treating doctor, in which case the treating doctor is not authorized); (B) ...On or after September 1, 2003, a doctor serving in one of the roles described in subsection (a)(1)(A) of this section is authorized as follows: (i) **a doctor whom the commission has certified to assign impairment ratings** or otherwise given specific permission by exception to, is authorized to determine whether an injured employee has permanent impairment, assign an impairment rating, and certify MMI" [emphasis added].

Review of the submitted documentation finds that the requestor was referred by the treating doctor to perform an examination of maximum medical improvement and impairment rating. The documentation also supports that the requestor's certification from the Division was valid at the time of service. Therefore, the requestor was authorized to evaluate maximum medical improvement and impairment rating at the time the services were performed.

3. 28 Texas Administrative Code §134.204 (j)(2) states, "An HCP shall only bill and be reimbursed for an MMI/IR examination if the doctor performing the evaluation (i.e., the examining doctor) is an authorized doctor in accordance with the Act and Division rules in Chapter 130 of this title."
28 Texas Administrative Code §134.204 (j)(3) states, "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. **Reimbursement shall be \$350**" [emphasis added].
28 Texas Administrative Code §134.204 (j)(4) states, "The following applies for billing and reimbursement of an IR evaluation. (C)(ii) The MAR for musculoskeletal body areas shall be as follows. (II) If full physical evaluation,

with range of motion, is performed: (-a-) **\$300 for the first musculoskeletal body area**" [emphasis added].

Review of the submitted documentation finds that the requestor performed an evaluation of maximum medical improvement and impairment rating, including a full physical examination with range of motion, as set out in 28 Texas Administrative Code §134.204 (j). Therefore, the requestor is entitled to \$650.00 reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$650.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$650.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	January 6, 2015 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.